WISCONSIN MEDICAID
PRIOR AUTHORIZATION / CHILD / ADOLESCENT DAY TREATMENT ATTACHMENT (PA/CADTA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all of the same information and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Providers should refer to the service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization/Child/Adolescent Day Treatment Attachment (PA/CADTA), HCF 11040, the physician prescription/order, evidence of a HealthCheck screen, and required documentation to the Prior Authorization Request Form (PA/RF), HCF 11018, and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616 or by mail to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

GENERAL INSTRUCTIONS

The information contained in this PA/CADTA will be used to make a decision about the amount of child/adolescent day treatment that will be approved for Medicaid reimbursement. Complete each section as completely as possible. Where noted in these instructions, the provider may attach material from his or her records.

Initial Prior Authorization Request
Complete the PA/RF and the entire PA/CADTA and attach the HealthCheck referral and physician order dated not more than one year prior to the requested first date of service (DOS). Label all attachments (e.g., “Day Treatment — Treatment Plan”). The initial authorization will be for a period of no longer than three months.

First Reauthorization
Complete the PA/RF and Sections I-III of the PA/CADTA. Attach a physician order for day treatment and a copy of the HealthCheck verification dated not more than one year prior to the requested first DOS. These materials may be copies of those included with the initial authorization request. Attach a summary of the treatment to date and any revisions to the day treatment services plan. Note progress on short- and long-term goals from the original plan. Be explicit in the summary as to the need for continued day treatment services. Authorization will be for a period of no longer than three months.

Second Reauthorization
Complete the PA/RF and Sections I-III of the PA/CADTA. Attach a copy of the physician order for day treatment and a copy of the HealthCheck verification dated not more than one year prior to the requested first DOS. These materials may be copies of those included with the previous authorization requests. Summarize the treatment since the previous authorization. The need for continued day treatment must be clearly documented. Where no change is noted in the treatment summary, justify the continued use of day treatment or note how changes in the treatment plan address the lack of progress. Specifically address aftercare planning. Authorization will be for a period of no longer than three months.

Subsequent Reauthorizations
Complete the PA/RF and Sections I-III of the PA/CADTA. Attach a copy of the physician order for day treatment and a copy of the HealthCheck verification dated not more than one year prior to the requested first DOS. These materials may be copies of those included with the previous authorization request. Attach a summary of the treatment since the previous authorization. Address why the recipient has not made transition to aftercare services. Strong justification will be required for day treatment services exceeding nine months per episode of treatment.

Check the appropriate box at the top of the PA/CADTA to indicate whether this request is an initial authorization, first reauthorization, second reauthorization, or subsequent reauthorization request. Make sure that the appropriate materials are included for the type of request indicated.

Multiple Services
When a recipient will require PA for other services concurrent to the child/adolescent day treatment (e.g., in-home treatment), a separate PA request must be submitted for those services along with the appropriate PA attachment and all required materials. The coordination of these concurrent services needs to be clearly indicated within the clinical documentation for all services. Other services must be identified on the multidisciplinary treatment plan(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial, exactly as it appears on the recipient's Medicaid identification card.

Element 2 — Age — Recipient
Enter the age of the recipient in numerical form (e.g., 16).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number exactly as it appears on the recipient's Medicaid identification card.

SECTION II — PROVIDER INFORMATION

Element 4 — Name — Day Treatment Provider
Enter the name of the Medicaid-certified day treatment provider that will be billing for the services.

Element 5 — Day Treatment Provider's Medicaid Provider Number
Enter the eight-digit Medicaid provider number for the day treatment provider. Providers will be assigned a unique provider number for the child/adolescent day treatment program.

Element 6 — Name — Contact Person
Enter the name of a person who would be able to answer questions about this request.

Element 7 — Telephone Number — Contact Person
Enter the telephone number of the contact person.

SECTION III — DOCUMENTATION

Element 8
Indicate the requested start date and end date for the authorization period. See the general instructions for information on the length of authorization that will be generally allowed. If the requested start date is prior to when the PA request will be received by Wisconsin Medicaid and backdating is needed, specifically request backdating and state clinical rationale for starting services before authorization is obtained. Requests may be backdated up to 10 working days on the initial authorization if appropriate rationale is provided.

Element 9
Indicate the total number of hours for which the provider is requesting Medicaid reimbursement for this PA grant period. The total number of hours should equal the quantity requested in Element 20 of the PA/RF.

Element 10

Present or attach a summary of the diagnostic assessment and differential diagnosis. Diagnoses on all five axes of the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) are required. The assessment should address the level of reality testing, thought processes, drive control, relational capacity, and defensive functioning. Not all Medicaid-covered child/adolescent day treatment services are appropriate or allowable for all diagnoses. Professional consultants base approval of services on a valid diagnosis, acceptable child/adolescent day treatment practice, and clear documentation of the probable effectiveness of the proposed service. **Providers may attach a copy of a recent diagnostic assessment.**

Note: A substance abuse assessment may be included. A substance abuse assessment must be included if substance abuse-related programming is part of the recipient's treatment program.

Element 11
If the recipient is on psychoactive medication, the treatment plan must include the name of the physician managing the medication(s). Describe or attach a summary of the recipient's illness/treatment/medication history. For individuals with significant substance abuse problems, the multidisciplinary treatment plan should indicate how these will be addressed. *Providers may attach copies of illness/treatment/medication histories that are contained in their records.*

Element 12
Complete the checklist to determine whether an individual meets the criteria for severe emotional disturbance (SED).

a. List the primary diagnosis and diagnosis code in the space provided. Not all Medicaid-covered child/adolescent day treatment services are appropriate or allowable. Professional consultants base approval of services on a valid diagnosis, acceptable child/adolescent practice, and clear documentation of the probable effectiveness of the proposed service. Federal regulations do not allow federal funding of rehabilitation services, such as child/adolescent day treatment or in-home or outpatient mental health and substance abuse services, for persons with a sole or primary diagnosis of a developmental disability or mental retardation.

b. Complete the checklist for determining whether an individual would substantially meet the criteria for SED.

c. Check all applicable boxes. The individual must have one symptom or two functional impairments.

1. **Symptoms**
   - Psychotic symptoms — Serious mental illness (e.g., schizophrenia) characterized by defective or lost contact with reality, often with hallucinations or delusions.
   - Suicidality — The individual must have made one attempt within the last three months or have had significant ideation about or have made a plan for suicide within the past month.
   - Violence — The individual must be at risk for causing injury to persons or significant damage to property as a result of emotional disturbance.

2. **Functional Impairments (compared to expected developmental level)**
   - Functioning in self care — Impairment in self care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs.
   - Functioning in the community — Impairment in community function is manifested by a consistent lack of age-appropriate behavioral controls, decision making, judgment, and a value system that result in potential or actual involvement in the juvenile justice system.
   - Functioning in social relationships — Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.
   - Functioning in the family — Impairment in family function is manifested by a pattern of significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness), inability to conform to reasonable limitations, and expectations that may result in removal from the family or its equivalent.
   - Functioning at school/work — Impairment in any *one* of the following:
     - ✓ Impairment in functioning at school is manifested by the inability to pursue educational goals in a normal time frame, such as consistently failing grades, repeated truancy, expulsion, property damage, or violence toward others.
     - ✓ Impairment at work is the inability to be consistently employed at a self-sustaining level, such as the inability to conform to work schedule, poor relationships with a supervisor and other workers, or hostile behavior on the job.

d. Check all applicable boxes:

The individual is receiving services from two or more of the following service systems:

- Mental health.
- Social services.
- Child protective services.
- Juvenile justice.
- Special education.

Eligibility criteria are waived under the following circumstance.

- Individual substantially meets the criteria for SED except the severity of the emotional and behavioral problems have not yet substantially interfered with the individual's functioning but would likely do so without child/adolescent day treatment services. Attach explanation.
- Substantially meets the criteria for SED except the individual has not yet received services from more than one system and in the judgment of the medical consultant, would be likely to do so if the intensity of treatment requested was not provided.

Element 13
Describe the treatment program that will be provided. Participation in specific groups/activities must be justified by the treatment plan. Attach a summary/description of groups or program components. The information presented should be adequate for determining that those services for which reimbursement is requested are Medicaid reimbursable.

Element 14
If not previously addressed, indicate the rationale for day treatment as opposed to other treatment modalities. If less intensive outpatient (clinic) services have not been provided, discuss why not. Providers should present this justification in their own words and not assume that the consultants can infer this from other materials presented with the request.

Element 15
Indicate the expected duration of day treatment. Describe services expected to be provided following completion of day treatment and transition plans. While providers are expected to indicate their expectations on the initial request, it is critical that plans for terminating day treatment be discussed in any requests for services at and beyond six months of treatment.

SECTION IV — ATTACHMENTS AND SIGNATURE

Element 16
The following materials must be attached and labeled.

a. Attach a copy of a physician's prescription/order dated not more than one year prior to the requested first DOS.

b. Attach verification that a HealthCheck screen has been performed by a valid HealthCheck screener not more than one year prior to the requested first DOS.

c. The treatment team must complete a multidisciplinary day treatment services plan. The plan must contain measurable goals, specific methods, and an expected time frame for achievement of the goals. The treatment plan must be tailored for the individual recipient.

The plan must clearly identify how specific program components relate to specific treatment goals. The documented methods should allow for a clear determination that the services provided meet criteria for Medicaid covered services. Services that are primarily social or recreational in nature, educational services, and mealtimes are not reimbursable.

d. Submit a copy of a substance abuse assessment if the psychiatric assessment indicates significant substance abuse problems and substance abuse-related services will be a part of the day treatment program. The assessment may be summarized in Element 10 as part of the psychiatric assessment or illness history. If the substance abuse problems will be addressed by some other agency, this should be indicated in the multidisciplinary treatment plan.

Element 17 — Signature — Day Treatment Program Director
The PA/CADTA request must be signed by the day treatment program director (psychologist or psychiatrist*).

Element 18 — Date Signed
Enter the month, day, and year the PA/CADTA was signed (in MM/DD/YYYY format).

* One who is licensed in Wisconsin and listed, or eligible to be listed, in the national register of healthcare providers in psychology.